DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185300	B. WING			12/	23/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE AT SU	MMERFIELD REHAB & WELLNE		1	877 FARNSLEY ROAD		
				L	OUISVILLE, KY 40216		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	was initiated on 12/22 12/23/2020. The facili compliance with 42 C regulations and has ir Medicare & Medicaid Centers for Disease C	d Infection Control Survey 2/2020 and concluded on ity was found to be in FR 483.80 infection control nplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for	F	000			
		SUPPLIER REPRESENTATIVE'S SIGNATUR	5		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## PRINTED: 01/15/2021

CENTERS FOR MEDICARE & MEDICARD SERVICES     OMB No. 0939.02       AND PLAN OF CORRECTION     (1) DENTIFICATION NUMBER:     (2) MULTIPIE CONSTRUCTION     (2) MULTIPIE CONSTRUCTIO	DEPART	IENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   COMPLETED     185300   B. WING   12/23/2020     NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   12/23/2020     SIGNATURE HEALTHCARE AT SUMMERFIELD REHAB & WELLNE   STREET ADDRESS, CITY, STATE, ZIP CODE   12/23/2020     (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID   PROVIDER'S PLAN OF CORRECTION SOURCE TO THE APPROPRIATE DEFICIENCY)   (K5) COMPLETIC PREFIX     TAG   A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/22/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000   Initial Comments   E 000	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     SIGNATURE HEALTHCARE AT SUMMERFIELD REHAB & WELLNE     (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   (X5) COMPLETIC DATE     E 000   Initial Comments   E 000   E 000     A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000								
SIGNATURE HEALTHCARE AT SUMMERFIELD REHAB & WELLNE   1877 FARNSLEY ROAD LOUISVILLE, KY 40216     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETIC DATE     E 000   Initial Comments   E 000   E 000   E 000   Fe 000   Fe 000     A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000   Fe 0			185300	B. WING _			12/	23/2020
SIGNATURE HEALTHCARE AT SUMMERFIELD REHAB & WELLNE     LOUISVILLE, KY 40216     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   (x5) COMPLETIC DATE     E 000   Initial Comments   E 000   E 000   E 000   Initial Comments   F 000     A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000   Initial Comments   Initial Comments<	NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LOUISVILLE, KY 40216     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   (X5) COMPLETIC DATE     E 000   Initial Comments   E 000     A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000	SIGNATUR				187	77 FARNSLEY ROAD		
PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETIC DATE     E 000   Initial Comments   E 000   E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000   Initial Comments   In	SIGNATUR	E HEALTHCARE AT 50	WWERFIELD REHAD & WELLINE		LO	DUISVILLE, KY 40216		
TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE     E 000   Initial Comments   E 000   E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related   E 000   Image: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE	(X4) ID							
E 000 Initial Comments E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related E 000					<			
A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related	170		,					
	E 000	A COVID-19 Focused Survey was initiated of concluded on 12/23/2 to be in compliance w	on 12/22/2020 and 020. The facility was found	EO	000	DEFICIENCY)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Office of Inspector General     STATEMENT OF DEFICIENCIES     AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:     100517			(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		12/23/2020			
	ROVIDER OR SUPPLIER	JMMERFIELD REHAL	ADDRESS, CITY, STATE, RNSLEY ROAD ILLE, KY 40216				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
N 000	was initiated on 12/2 12/23/2020. The faci	d Infection Control Survey 2/2020 and concluded on lity was found to be in t to 42 CFR 483.80. Total	N 000				

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